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STATISTICAL BULLETIN

METROPOLITAN LIFE INSURANCE COMPANY

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The Depression and World Health

WE HAVE repeatedly called attention in the STATISTICAL BULLETIN to the fact that the economic depression, which has now lasted for more than three years, has not as yet affected adversely the health of the people in the United States. Indeed, measured by the deathrate, the public health has actually shown improvement concurrent with increasingly unfavorable economic conditions. Even in 1933, which started badly, the health situation has cleared up to such an extent that the March mortality rate is as low as it has ever been. The sickness rate, as measured by the records of the reportable diseases, is also low. We have had no serious or widespread outbreaks of any disease, except influenza; and influenza epidemics occur in good times as well as bad.

All available information shows, furthermore, that in Europe as well, there is as yet no evidence of deterioration of the health of the people. A recent study by the HEALTH ORGANIZATION OF THE LEAGUE OF NATIONS shows that despite the social disturbances that inevitably accompany widespread unemployment, both the deathrates and the sickness rates are extremely low. As examples of this, the 1932 deathrate up to mid-year, in 50 German towns was lower than for years; and the rate in 118 English towns well below the average for eight years. In Germany, Hungary, Italy, the Netherlands, Poland and Czecho-Slovakia, the mortality rate of 1931 was well below the average for the five-year period 1926-1930; and in the United Kingdom it was precisely at this average.

In Europe, as in America, health authorities are nevertheless concerned over the future effects of the depression on the public health. There is no support in either continent for the thesis that, in the long run, health is benefited by world-wide economic disturbances. It is for this reason that the Health Organization of the League of Nations is now giving serious study of the ultimate effects of the depression on world health. The League, through its Health Organization, has already taken the matter up with SURGEON-GENERAL HUGH S. CUMMING of the UNITED STATES PUBLIC HEALTH SERVICE. General Cumming has agreed that, so far as the United States is concerned, the following well-known health experts will be assigned to study the subject: Mr.

EDGAR SYDENSTRICKER, formerly a member of the Health Section of the League of Nations and now Director of Research of the Milbank Memorial Fund; DR. LOUIS I. DUBLIN, Third Vice-President and Statistician of the Metropolitan Life Insurance Company; DR. WALTER F. WILLCOX, Professor Emeritus of Economics and Statistics, Cornell University; and DR. SELWYN D. COLLINS, Senior Statistician, United States Public Health Service. They will meet in May.

Nineteen Thirty-two a Record Health Year in Canada

IN Canada, as in the United States, 1932 was a record health year. This is indicated by the very low deathrate of nearly one and one-quarter millions of Canadians who are insured in the Industrial Department of the Metropolitan Life Insurance Company.

The rate among these insured Canadians declined, in 1932, to the very low point of 7.7 deaths per thousand insured lives. This is a drop of 4.3 per cent. from the previous minimum recorded in 1931. In the face of increasingly unfavorable business conditions, the public health has been maintained. The people of Canada are to be congratulated on their good fortune; for the reduction that has taken place represents the saving of many lives and the prevention of an even larger number of cases of illness. Such gains are especially gratifying in periods of economic disturbance.

Remarkable changes have taken place in the mortality rates of important diseases among the Canadian wage-earning population. In the brief period of seven years, the deathrate for the four principal communicable diseases of childhood has been reduced nearly two-thirds; that for pneumonia nearly two-fifths; for diarrheal diseases, more than one-half; and for puerperal conditions, more than one-fifth. The tuberculosis deathrate has dropped also, but the decline has not kept pace with that recorded among the insured in the United States. The same is true for typhoid fever.

The suicide and homicide experiences of Canadian policyholders are low. Year after year the Canadian suicide deathrate runs from one-third to two-fifths the American figure. Suicides, in 1932, actually declined in Canada in contrast to a considerable rise in the States. Homicides have always been a negligible item in Canadian mortality statistics, the mortality rate in that country being only about one-sixth of that for white policyholders living in the United States.

The gain in control over preventable disease and premature death in Canada in recent years is an extraordinary achievement, and at once places this country among the leaders in sanitary science and public health work in the whole world. It is especially gratifying to note in the

current figures (see Table below), how great has been the improvement in the Province of Quebec. The recent advances in public health organization in that Province, and more especially the establishment of the large number of county health units, have already borne fruit. Much of the improvement in the Canadian deathrate in recent years has in fact been due to the progress made in Quebec. For example, the rate for the four principal communicable diseases of childhood was reduced from 80 per 100,000 in 1926, to only 27 in 1932; that for pneumonia, from 120 to 72; and that for tuberculosis, from 143 to 108. The most noteworthy drop of all, however, has been that for diarrheal

Deathrates per 100,000 from Principal Causes in Canada and the Provinces of Ontario and Quebec. Metropolitan Life Insurance Company, Weekly Premium-Paying Business, Industrial Department. (All Ages.) 1926 to 1932.

Total—All Causes	Deathrates per 100,000								
	1932			1929			1926		
	Canada	Ontario	Quebec	Canada	Ontario	Quebec	Canada	Ontario	Quebec
All Causes of Death	772.7	674.8	879.3	917.8	760.8	1094.8	913.8	662.4	1161.5
Typhoid fever	4.4	1.9	6.5	4.7	3.0	7.1	5.7	2.4	8.8
Communicable diseases of childhood	21.8	15.4	26.7	48.9	34.3	55.5	56.8	26.4	80.0
Measles	5.4	5.5	5.4	8.4	6.4	7.5	10.7	5.7	13.1
Scarlet fever	3.1	2.2	3.5	7.3	3.3	11.1	7.1	3.8	9.1
Whooping cough	5.5	2.5	7.7	11.3	7.6	11.3	22.1	9.5	32.8
Diphtheria	7.8	5.2	10.0	21.9	17.0	25.7	16.9	7..	25.0
Influenza and pneumonia	86.0	68.4	102.3	159.5	129.6	192.6	145.1	98.5	187.9
Influenza	28.3	22.5	30.7	57.4	44.2	63.0	49.0	26.1	67.9
Pneumonia	57.7	45.8	71.6	102.1	85.4	129.6	96.1	72.4	120.0
Tuberculosis—All forms	82.5	42.8	108.1	96.8	50.1	134.7	102.0	55.8	142.6
Tuberculosis of respiratory system	65.9	34.3	88.3	77.2	37.6	108.6	81.9	44.4	115.3
Cancer—All forms	76.6	74.1	71.9	63.6	60.7	64.0	57.2	59.9	52.8
Diabetes mellitus	15.2	18.7	13.3	9.2	9.7	8.7	9.0	8.4	11.0
Cerebral hemorrhage, apoplexy	40.2	56.5	33.7	35.3*	38.6*	26.4*	30.8*	37.0*	27.2*
Diseases of heart†	89.6	106.0	81.4	84.4	92.5	78.4	84.6	96.1	83.6
Diarrhea and enteritis	48.1	15.9	80.4	79.5	31.8	127.2	98.6	19.6	173.5
Chronic nephritis (Bright's Disease)	40.6	27.2	55.5	37.7	24.	53.6	39.2	23.9	55.8
Puerperal state—Total	14.6	11.3	16.1	15.3	1 .7	12.0	18.4	18.2	20.7
Total external causes	49.2	49.7	46.3	5[illegible].3	6[illegible].5	43.6	47.9	44.4	50.9
Suicides	3.4	4.9	2.3	3.1	3.[illegible]	2.1	2.8	2.7	3.0
Homicides	.3	.3	.5	.2	.3	.3	.4	.3	.6
Accidents—Total	45.5	44.5	43.5	53.0	60.0	41.1	44.7	41.4	47.4
Automobile accidents	10.5	10.7	9.8	13.2	15.0	9.4	8.5	8.2	9.0
Other diseases and conditions	203.8	186.9	237.1	226.6	207.6	291.0	217.9	171.7	266.6

*Rates not strictly comparable with those for 1932, due to changes in classification procedure.
†Excludes pericarditis, acute endocarditis, acute myocarditis and angina pectoris.

complaints. Only a few years ago this condition was actually the leading cause of death in Quebec, with a rate of 173.5 per 100,000; last year the figure was 80.4, a reduction of more than half within seven years. It is quite obvious that an intensive public health campaign, made possible by the organization of full-time county health units, has had its effect. Children are now immunized against diphtheria, infant welfare is stressed, and there is no reason why, in a short period, the Province of Quebec cannot attain the very low mortality rates which have always characterized the sister Province of Ontario. Such an achievement will place Canada along with Australia and New Zealand among the countries having the highest expectations of life.

The progress that has been made in Canadian health conditions has been due, in large measure, to the support which the health departments have received from their governments in recent years. It is very much hoped that the excellent organizations already established will continue to receive the same encouragement and support during this period of world-wide economic disturbance, when the maintenance of the public health is even more important than ever.

Mortality Experience of the First Three Months of 1933

ALTHOUGH 1933 began unfavorably from the standpoint of the public health, the situation has already taken a marked turn for the better. The high deathrates which prevailed in January and February were followed by the lowest mortality for March which has ever been observed during this month, with a single exception. The year's bad start was due to an influenza epidemic which began late in 1932 and extended into January and February of the current year.

The deathrate for the Metropolitan Industrial policyholders for the first quarter of 1933 was 10.1 per thousand, or approximately 8 per cent. higher than for the like period of last year. Among the colored policyholders the much smaller rise of 5.2 per cent. was recorded.

Influenza and Pneumonia

Nearly one-sixth of the deaths from all causes combined were due to influenza or pneumonia. Even this figure does not fully measure the toll of life which must be attributed to this latest influenza outbreak; for increased deathrates from the principal degenerative diseases accompanied this epidemic just as has been the case with every serious influenza outbreak in the past.

Heart Disease Again the Leading Cause of Death

Approximately one-fifth of all the deaths during the quarter were

charged to heart disease. The upward trend for cardiac conditions is still in evidence, and the deathrate in 1933 bids fair to exceed by a considerable margin the previous maximum which was reached last year. The mortality from cerebral hemorrhage rose nearly 9 per cent., and there was a small increase for chronic nephritis.

Cancer Mortality at New High Point

The mortality from cancer continues to rise alarmingly. The deathrate for the quarter was 7.6 per cent. above that for the like part of 1932. The cancer deathrate among Metropolitan Industrial policyholders rose nearly 8 per cent. last year; and if conditions do not change for the better during the remainder of 1933, we shall observe about the same increase at the completion of the year. The cancer deathrate in more recent years has shown a larger rise among the white Industrial policyholders than among the colored.

Diabetes

The diabetes deathrate for the quarter (29.2 per hundred thousand) is nearly 20 per cent. higher than that for the corresponding months of 1932. The mortality from diabetes is now higher than ever before and the rise has been particularly marked among the white Industrial policyholders.

Suicides and Accidents Increase

Suicides show a 10.2 per cent. increase and accidents a 3.2 per cent. rise as compared with the first quarter of last year.

Where the Rate Has Declined

Typhoid fever, measles, whooping cough, diphtheria, tuberculosis, diarrheal diseases, puerperal conditions, homicides and automobile fatalities are the causes which show deathrates more or less lower than those for the first quarter of 1932.

Diphtheria

The diphtheria deathrate for the quarter is at the remarkably low figure of 2.9 per hundred thousand, as compared with 5.5 for the same period a year ago. It is interesting to compare this current deathrate with that which obtained only ten years ago—that is, during the first quarter of 1923. The figure then was 22.0 per hundred thousand, or nearly 8 times the 1933 deathrate. Ten years ago the mortality rate for diphtheria alone was approximately twice as high as that which obtains today for measles, scarlet fever, whooping cough and diphtheria combined. This disease is clearly on the way to complete control.

Tuberculosis Still Declining

Even during January and February, when a high general mortality rate prevailed, the tuberculosis deathrate was low. At the end of the first quarter it shows a drop of 2.8 per cent. from the figure of last year. The improvement, however, has been mainly among the negro Industrial policyholders.

Deathrates per 100,000 Persons Exposed. First Quarters of 1931, 1932, 1933 Compared. By Color for Principal Causes of Death. All Ages. Metropolitan Life Insurance Company, Weekly Premium-Paying Industrial Business.

Causes of Death	Deathrates per 100,000 Persons Exposed					
	White			Colored		
	Jan.-Mar. 1933*	Jan.-Mar. 1932	Jan.-Mar. 1931	Jan.-Mar. 1933*	Jan.-Mar. 1932	Jan. Mar. 1931
Total—All Causes	927.9	852.9	924.1	1638.7	1557.2	1763.5
Typhoid fever	.8	1.2	1.0	1.4	1.9	1.8
Measles	1.9	3.0	4.0	.2	1.3	2.2
Scarlet fever	4.2	4.1	4.5	1.8	1.3	1.0
Whooping cough	3.1	3.6	4.1	.7	3.8	5.1
Diphtheria	3.1	6.0	6.2	1.4	1.9	3.0
Influenza	49.6	24.7	40.7	97.3	56.5	104.3
Meningococcus meningitis	1.8	1.4	2.6	2.7	2.1	9.3
Tuberculosis (All forms)	56.4	56.9	63.7	183.3	197.4	236.1
Tuberculosis of respiratory system	51.1	50.7	56.9	164.6	177.8	212.5
Tuberculosis of the meninges, etc.	2.1	2.6	2.5	5.5	4.4	4.3
Other forms of tuberculosis	3.2	3.6	4.3	13.3	15.2	19.3
Cancer (All forms)	95.4	87.9	84.1	100.5	98.8	90.3
Diabetes mellitus	28.9	23.6	24.2	31.6	30.3	27.4
Alcoholism	2.5	2.7	3.2	2.3	5.1	3.7
Cerebral hemorrhage; apoplexy	66.5	59.5	59.1	137.1	139.3	138.9
Diseases of heart†	178.4	158.0	160.1	307.6	254.3	278.9
Total respiratory diseases	106.6	97.1	131.2	177.8	193.6	259.0
Bronchitis	3.6	2.9	4.2	5.5	5.9	4.5
Bronchopneumonia	39.2	33.3	50.4	47.1	48.9	74.1
Pneumonia (lobar and undefined)	56.0	53.2	67.5	114.0	124.9	164.4
Other diseases of respiratory system	7.8	7.7	9.1	11.2	13.9	16.0
Diarrhea and enteritis	7.0	8.4	10.4	6.4	5.7	10.8
Under 2 years	5.4	6.3	8.2	2.1	1.7	3.9
2 years and over	1.7	2.1	2.2	4.3	4.0	6.9
Acute nephritis	2.2	3.3	4.0	11.2	9.3	13.2
Chronic nephritis (Bright's Disease)	65.8	65.3	66.1	152.9	144.1	146.4
Puerperal state—Total	9.8	10.8	11.2	17.4	15.4	17.9
Total external causes	64.6	62.4	63.4	97.3	95.9	107.4
Suicides	11.0	10.1	9.5	9.6	7.0	5.7
Homicides	3.0	3.3	3.5	28.6	31.6	30.7
Accidents—Total	50.6	49.0	50.4	59.0	57.3	71.0
Automobile accidents	17.5	18.2	17.9	17.6	18.8	22.3
All other diseases and conditions	179.4	173.1	180.6	307.8	299.4	306.9

*The rates for 1933 are subject to slight correction, since they are based on provisional estimates of lives exposed to risk..

†Excludes pericarditis, acute endocarditis, acute myocarditis and angina pectoris.

Deaths from Puerperal Conditions Drop

The deathrate from diseases arising out of pregnancy and childbirth continues to decline among insured white women, although it has increased somewhat this year among the colored. For both races com-

bined there has been a drop, as compared with the first quarter of 1932, of 5.3 per cent. A declining birthrate has played an important rôle in the practically continuous drop in deaths from puerperal causes which we have observed among insured women since 1922.

Accidents and Homicides

Although the deathrate for all types of accidents combined has increased slightly, there has been a drop this year in automobile fatalities. The homicide deathrate has declined more than 9 per cent. since last year.

The table on page 6 presents the deathrates among white and colored Industrial policyholders respectively for the first three months of 1933, 1932 and 1931.

The Chances of Dying from Diabetes

DIABETES today presents a serious and growing public health problem. Nothing illustrates this better than the probability of dying from the disease, based on recent mortality rates, as compared with the probabilities based on deathrates in earlier years. Under present conditions, 15 out of every 1,000 white males born will eventually die of diabetes and 27 out of every 1,000 white females born. These probabilities are based on the 1930 deathrates. Only ten years before that the probability at birth of eventually dying from diabetes was only 13 in 1,000 for white males and 18 for white females. Thus, in the period of ten years this probability has increased nearly one-sixth for males and a half for females.

We have computed the chances of eventually dying from diabetes at successive ages of life for the two sexes separately, according to mortality statistics of 1920 and 1930. Considering first white males, it will be seen that the probability of eventually dying increases sharply between birth and age five, and then increases very slowly. In 1930, the maximum probability for males was reached about age 55. At that age, close to 18 in each 1,000 living would be expected to die eventually from diabetes if the 1930 rates continued to prevail. The probabilities for males on the basis of the 1930 rates are consistently higher at every age than in 1920.

It is among females, however, that diabetes is causing the gravest concern. Among them, too, there is an abrupt increase between birth and age five in the probability of eventually dying from diabetes. After age five the probability increases slowly with age, as among males, but reaches its maximum about age 50, when, if these 1930 rates continued to prevail, 31 out of every 1,000 women may be expected to die eventually from the disease. After age 50, the probability declines at first slowly, but then sharply so that, at age 80, the probability is only 10 in a thousand. These probabilities for females,

based on 1930 deathrates, are considerably higher at every age than in earlier years. They are almost consistently 50 per cent. higher than the probabilities based on the 1920 mortality rates.

How preeminently diabetes is a problem in females is clearly seen by comparing the probabilities for each sex in 1920 and 1930. In 1920, the probability for females at birth showed an excess of 37 per cent. over that for males. In 1930, the probability for females showed an excess of 81 per cent. over males.

It will be appreciated how far diabetes has advanced to its present importance by comparing the probabilities of ultimately dying from it with the probabilities of dying from tuberculosis. This is illustrated clearly in the chart on page 10. On the basis of mortality conditions in 1930, at all ages past 30, the probability, among women, of dying from diabetes is greater than the probability of dying from tuberculosis. On the basis of mortality only ten years before, the two probability curves for women did not cross until age 60. Among men, the situation is quite different. The probability of dying from diabetes does not exceed that of tuberculosis until about age 60, but in 1920 the two lines did not cross until age 80 was reached.

In a very real sense, there is a paradox in the present diabetes situation. There has been an unquestionable improvement in the treatment of the disease. Nevertheless, there has occurred simultaneously an increase in the number of deaths. The only logical conclusion is that today many more cases are occurring than did in the past. Unfortunately, we do not have exact data on this matter, such as registration of the tuberculous gives us; if we did, we should not be in the dark as to this increase and its extent.

This increase in the incidence of diabetes is a two-fold one. Only part of it may be called a real increase. On the one hand, the number of cases which are recognized has grown rapidly through the expansion of medical facilities, improvements in the technique of diagnosis and the increased use of these techniques. Not only are sick persons more thoroughly examined, but early cases are being picked up in greater numbers through the examination of supposedly healthy persons. In this, an increase in the examinations for life insurance has played a prominent part. There have also been shifts in the age and sex composition of our population and in its racial structure, all of which have been in the direction of increasing the proportions in our population of those groups in which the incidence of diabetes is highest. In a sense, the increase in the number of diabetics from these sources may be called an apparent increase. All of the improvement in medical facilities and in early discovery through more thorough and frequent examination of persons, both in health and sickness has not

really added a single case to the number of diabetics. It has merely enabled us to identify more cases than before, and when death occurred these cases have been registered as deaths from diabetes, whereas in the past many of them were not so diagnosed and were registered as deaths from other causes.

In contrast with these items, a number of causes have been at work during the last generation which have, in a very real sense, increased the number of diabetics. The first of these social forces was the improvement in the standards of life of the population. During the last generation, there was a very appreciable improvement in the economic condition of the people. Real wages increased, and with this came an increase in the buying power of the people. On all sides, the average man and woman could enjoy, and did enjoy, the use of more and more food and other comforts of life. At the same time that this rise in the standards of life took place, and possibly as a concomitant of it, was an increase in the use of machinery and a greater mechanization of industrial processes. More and more people took to industrial employment, and in such employment were called upon to a lesser degree to use their energy in the production of work. Nor was this shift from manual to mechanical labor limited to industry. It permeated the farms and the homes, so that the entire population was relieved of much of the hard and heavy work which in previous generations was a part and parcel of the daily life of the people. So we are confronted with two forces, both operating to disturb the metabolic equilibrium of large numbers of persons. On the one hand, more food materials were taken in, and, on the other, less energy was called upon to burn it up. The net result was overfeeding, and, in the long run, an increase in the number of overweight, and even obese, persons. It is among such individuals that diabetes takes its greatest toll. In this sense, the very conditions of life in the present generation have made the increase of diabetes almost inevitable.

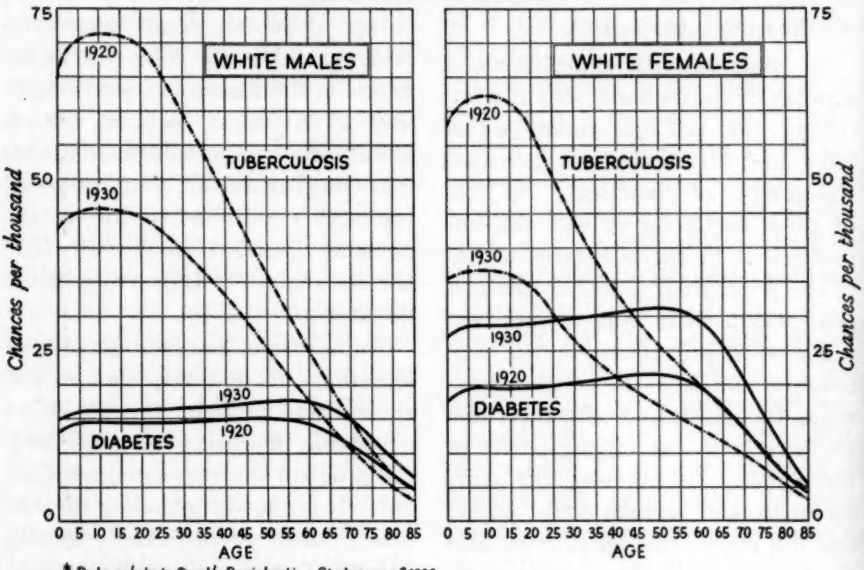
On the whole, however, the present situation in diabetes should not cause us to despair. So far as its increasing mortality is concerned, the problem is a very circumscribed one. It is one of controlling the disease in older people, chiefly among women. To some extent, the increase at these older ages need not surprise us. Insulin does not cure diabetes. It does, however, prolong lives of diabetics; so much so, that most of them reach ages at which they succumb, much as do other old persons, to the diseases typical of later life—heart disease, nephritis, arteriosclerosis, and cerebral hemorrhage. These diseases occur relatively early among non-diabetic persons who are overweight, and it is not surprising that diabetics, most of whom are overweight, should suffer in this way.

On the other hand, there are many things we can do to improve this diabetes situation. There are too

many premature deaths from coma. We can postpone death from cardiovascular degeneration to a much greater extent than we have succeeded in doing. There are even today large numbers of cases which are not diagnosed as early as they should be. All this calls for action.

CHANCES OF EVENTUALLY DYING FROM DIABETES AND FROM TUBERCULOSIS

United States* 1920 and 1930



* *Data relate to Death Registration States as of 1920*

Health Record for March, 1933

MARCH ushered in a pronounced improvement in health conditions, with the result that the deathrate among Metropolitan Industrial policyholders was the lowest on record for that month with a single exception. The figures for this year are much lower than for March, 1932 for influenza and pneumonia and for a number of other important diseases.

The deathrate in the large cities of the United States, in March, was 11.8 per thousand estimated population as compared with 12.2 during February and 13.6 in March of last year. More cases of measles, scarlet fever, smallpox and typhoid fever were reported in March than in February, together with less sickness from diphtheria, influenza and poliomyelitis. As compared with March, 1932, there was higher prevalence of measles and scarlet fever, but less diphtheria, influenza, poliomyelitis, smallpox and typhoid fever.

Measles cases, as reported from 33 states, increased in March, particularly in California and in New York.

The following table shows the mortality among Industrial policyholders for March, 1933; February, 1933, and March, 1932, together with the cumulative rates for the first three months of each year.

METROPOLITAN LIFE INSURANCE COMPANY

Deathrates per 100,000 for Principal Causes. Weekly Premium-Paying Business in Industrial Department. All Ages (Annual Basis).*

MONTHS OF MARCH, 1933; FEBRUARY, 1933 AND MARCH, 1932

CAUSES OF DEATH	ANNUAL RATE PER 100,000 LIVES EXPOSED*				
	Mar. 1933	Feb. 1933	Mar. 1932	Cumulative Jan.-March	
				1933	1932
TOTAL—ALL CAUSES	959.8	954.8	1033.7	1005.5	929.8
Typhoid fever	.8	1.0	.9	.9	1.3
Measles	2.3	1.3	3.6	1.7	2.8
Scarlet fever	3.8	3.5	4.9	3.9	3.8
Whooping cough	2.8	2.2	4.5	2.8	3.6
Diphtheria	1.8	3.1	4.0	2.9	5.5
Influenza	28.0	46.9	43.2	54.8	28.2
Tuberculosis (All forms)	73.3	65.7	76.2	70.2	72.2
Tuberculosis of respiratory system	65.6	59.2	68.4	63.5	64.6
Cancer (All forms)	93.7	93.4	92.3	95.9	89.1
Diabetes mellitus	26.6	25.6	27.4	29.2	24.4
Cerebral hemorrhage, apoplexy	75.3	70.8	76.8	74.2	68.2
Diseases of heart†	182.6	181.9	187.0	192.5	168.5
Pneumonia (All forms)	89.9	94.8	122.6	102.4	96.1
Other respiratory diseases	10.9	13.1	13.2	12.0	11.6
Diarrhea and enteritis	7.0	6.4	7.4	7.0	8.1
Chronic nephritis (Bright's disease)	74.3	72.2	78.2	75.3	73.9
Puerperal state—total	10.1	10.0	11.2	10.7	11.3
Suicides	11.2	8.7	9.3	10.8	9.8
Homicides	5.4	5.3	6.3	5.8	6.4
Accidents—total	48.5	47.2	50.3	51.5	49.9
Automobile accidents	16.4	15.6	15.6	17.5	18.2
All other diseases and conditions	211.5	200.9	214.4	201.0	195.3

*The rates for 1933 are subject to slight correction, since they are based on provisional estimates of lives exposed to risk.

†Excludes pericarditis, acute endocarditis, acute myocarditis and angina pectoris.

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STATISTICAL BULLETIN,

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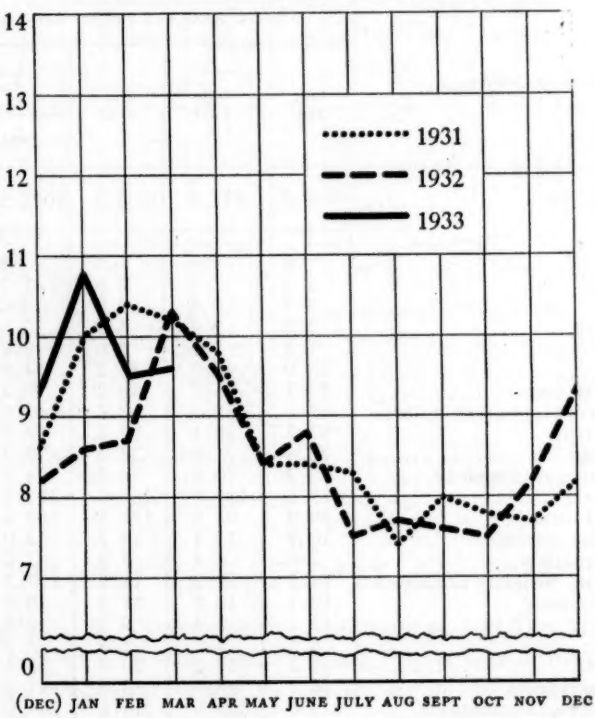
DEATHRATES FROM ALL CAUSES

in the Metropolitan Life Insurance Company
Industrial Department

DEATHRATE PER 1,000—ANNUAL BASIS



1931	10.0	10.4	10.2	9.8	8.4	8.4	8.3	7.4	8.0	7.8	7.7	8.2
1932	8.6	8.7	10.3	9.5	8.4	8.8	7.5	7.7	7.6	7.5	8.2	9.3
1933*	10.8	9.5	9.6									

**Rates for 1933 are provisional.*

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